Before the
Administrative Hearing Commission
State of Missouri

STATE BOARD OF NURSING,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 11-0543 BN
	)	
DENISE E. ZIMBRIC,	)	
	)	
Respondent.	)	

REVISED DECISION

We find no cause exists to discipline Denise Zimbric's registered nurse license.

Procedure

On March 24, 2011, the State Board of Nursing ("the Board") filed a complaint seeking to discipline Denise Zimbric's license as a registered nurse ("RN"). On April 6, 2011, we sent a notice of complaint and hearing notice to Zimbric. Zimbric filed her answer on May 10, 2011. We held a hearing on this matter on March 30, 2012. Tina M. Crow Halcomb represented the Board. Richard Blanke represented Zimbric, who was also present. The matter became ready for our decision on September 10, 2012, the date the last written argument was due.

Findings of Fact

1. The Board is an agency of the State of Missouri, created and established by Missouri law for the purpose of executing and enforcing Chapter 335[1], the Nursing Practice Act.

[1] Statutory references, unless otherwise noted, are to RSMo Supp. 2012.

2. Zimbric is licensed by the Board as a RN. Zimbric's license is current and active and was at all times relevant to this case.

3. Since earning her RN certificate at Saint Luke's Hospital School of Nursing in 1969, Zimbric has received regular training and numerous certifications and has had extensive experience in emergency care and emergency management.

4. At all times relevant to this case, Zimbric was employed by Barnes Jewish Hospital in St. Peters, Missouri ("Barnes") as a RN in the emergency department. Zimbric had been employed as a RN in the Barnes emergency department since 1986.

5. Zimbric was placed on an action plan for three months in April 2008 due to a lack of follow through on following standing orders for patients.

6. Kathy Crist became manager of emergency services at Barnes and Zimbric's direct supervisor in June 2008.

7. On August 18, 2008 Zimbric was verbally counseled regarding her care and treatment of H.M. in the emergency room on August 13, 2008 and failure to make the rounds of her patients every thirty minutes.

8. A complaint filed by H.M.'s wife regarding the treatment H.M. received in the emergency room on August 13, 2008 does not mention Zimbric, but is very critical of the doctor responsible for H.M.'s care.

9. On August 19, 2008, Zimbric was suspended from her position at Barnes during an investigation into discrepancies in the documentation of her administration of medications to patients, including controlled substances.

10. At all times relevant to this case, Donna Payne was the associate administrator of nursing at Barnes.

11. On August 22, 2008, Zimbric resigned from her position at Barnes after her supervisors, Payne and Crist, gave her the choice of being fired and forfeiting five weeks' accumulated vacation time or voluntarily resigning and retaining the vacation benefit.

12. On September 12, 2008, the Board received Payne's complaint dated September 9, 2008.

13. Payne's complaint to the Board cites discrepancies in documentation of Zimbric's administration of medications to patients on August 4 and 14, 2008, the action plan and non-specific concerns of the Medical Director with regard to Zimbric's assessment and care of patients.

The seven-week-old patient

14. In January 2008, a seven-week-old patient came into the emergency room vomiting and showing signs of dehydration.

15. As part of the regular protocol for evaluating a patient in the emergency room, Zimbric was required to start an IV and record vital signs.

16. The special equipment to read an infant's oxygen levels and blood pressure could only be connected to a portable machine that records the readings. That machine was not charged at the time the infant was in the emergency room.

17. Zimbric obtained an oximeter from the respiratory therapy department that did not need to be connected to the portable machine and recorded the infant's oxygen levels in approximately fifteen minutes.

18. Although the uncharged portable machine could record blood pressure readings if it was plugged in, the machine had the wrong adapter on it to fit the connection from the specialized infant blood pressure cuff.

19. In order to record the blood pressure readings from the infant cuff, Zimbric had to find another cuff that had the right type of adapter and find a way to attach the adapter to the infant cuff.

20. Zimbric obtained the blood pressure readings after approximately thirty minutes.

Patient H.M.

21. H.M. was a hospital patient on August 13, 2008.

22. Zimbric documented H.M.'s vital signs, the removal of the dressing on H.M.'s wound, and her observations about the condition of the wound.

23. Zimbric removed the bloody dressing on H.M.'s wound in order to document the condition of the wound.

24. Zimbric replaced the dressing with loose sterile gauze with a little paper tape to keep the wound covered because the wound was not bleeding. Zimbric expected the patient to see the doctor in fifteen minutes.

25. Zimbric was with H.M. from approximately 5:15 pm until 5:30 pm.

26. The rule in the emergency room was to make rounds of patients every hour.

The Vicodin allegation

27. On August 18, 2008, a routine narcotics inventory revealed a discrepancy of 7.5 milligrams of vicodin.

28. Zimbric assisted in that inventory.

29. Barnes' emergency room uses an automated medication management system known as "Pyxis" to dispense and track medications. A personal code is necessary to access the system and medications are dispensed and tracked by patient.

30. The Pyxis report showed that on August 14, 2008, Zimbric withdrew one vicodin pill for J.L. and two vicodin pills for S.M.

31. Zimbric gave S.M. dicyclomine hydrochloride for her upset stomach and later gave her toradol, a non-narcotic pain killer. These medications were properly recorded in the Pyxis system and on S.M.'s chart.

32. A flaw existed in the Pyxis system. If a user did not log off, the system would keep them logged in for three minutes. During this time someone else could use the system to withdraw medication. This withdrawal would appear on the report under the first user's name and login code and the name of the patient for whom the first user was withdrawing medications at the time.

33. The common practice in the emergency room was for a nurse to log Zimbric off of the Pyxis system and log herself (or himself) on before the three minutes were up.

34. When Zimbric withdrew medications for S.M. and J.L., someone asked to use the Pyxis system while Zimbric was preparing medications and waiting for a receipt.

35. Zimbric assumed whoever it was behind her had signed her out before logging in with their own code.

36. The Pyxis report confirms that the vicodin for S.M. was withdrawn right after the dicyclomine hydrochloride.

Evidentiary Rulings

At the hearing, the Board proffered Exhibits 5 and 6. These exhibits contained Crist's documentation of Zimbric's verbal counseling session on August 18, 2008 and suspension on August 19, 2008. Zimbric objected to statements made by Drs. Gunning, Reed and Landry.

The statements made by the doctors are clearly hearsay. We sustain the objections to the hearsay statements made by the doctors. The remainder of these exhibits contain statements by Zimbric, which are admissible as admissions of a party-opponent, and statements made by Crist as part of her investigation that detail her reasons for the investigation. Further, many of

Crist's statements are necessary to understand Zimbric's admissions. The remainder of Exhibits 5 and 6, excluding the statements of the doctors, are admissible.

Hearsay objections to Crist's testimony about what she was told by another nurse regarding a narcotics inventory and to Crist's handwritten notations on a Pyxis report allegedly reflecting information in patient files Crist reviewed in connection with Zimbric's administration of medications were taken with the case. We admit this evidence solely to show the reasons for Crist's investigation. We do not rely on this evidence for the truth of these statements.

Conclusions of Law

We have jurisdiction to hear the complaint.[2] The Board has the burden of proving that Zimbric has committed an act for which the law allows discipline.[3] The Board alleges that there is cause for discipline under section 335.066.2:

> 2. The board may cause a complaint to be filed with the administrative hearing commission as provided by chapter 621 against any holder of any certificate of registration or authority, permit or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his or her certificate of registration or authority, permit or license for any one or any combination of the following causes:
>
> (1) Use or unlawful possession of any controlled substance, as defined in Chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by sections 335.011to 335.096;
>
> ***
>
> (5) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 335.011 to 335.096;
>
> (6) Violation of, or assisting or enabling any person to violate, any provision of sections 335.011 to 335.096, or of any lawful rule or regulation adopted pursuant to sections 335.011 to 335.096;

[2] Section 621.045..
[3] *Missouri Real Estate Comm'n v. Berger*, 764 S.W.2d 706, 711 (Mo. App. E.D. 1989).

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(12) Violation of any professional trust or confidence;

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(14) Violation of the drug laws or rules and regulations of this state, any other state or the federal government [.]

Credibility

This Commission must judge the credibility of witnesses, and we have the discretion to believe all, part, or none of the testimony of any witness.[4] When there is a direct conflict in the testimony, we must make a choice between the conflicting testimony.[5]

At the hearing, Crist testified by telephone and Zimbric testified in person. Crist's testimony was inconsistent and not credible. We find Zimbric's testimony to be credible due to her extensive experience and her demeanor.

The Board's complaint is based on three incidents involving patients and an allegation that Zimbric illegally and improperly dispensed controlled substances. The testimonies of the Board's witness and Zimbric differ in significant details. Additionally, the weight of much of Crist's testimony must be considered in light of the hearsay nature of the testimony and related evidence. We find Zimbric's testimony to be more credible.

Seven-week-old patient

In January 2008, a seven week old patient came into the emergency room vomiting and showing signs of dehydration. As part of the regular protocol for evaluating a patient in the emergency room, Zimbric was required to start an IV and record vital signs.

The Board alleges that the pediatric supervisor in the emergency room at the time, Dr. Gunning, expressed concern that Zimbric did not appropriately care for the infant and that her

[4]*Harrington v. Smarr*, 844 S.W.2d 16, 19 (Mo. App. W.D. 1992).
[5]844 S.W.2d at 19.

performance resulted in a lack of trust from Dr. Gunning and other staff. Although Crist was not yet employed in the emergency room at that time, she testified that Dr. Gunning told her that Zimbric had difficulty getting the infant's blood pressure and oxygen saturation levels and that her performance resulted in a lack of trust from Dr. Gunning. Dr. Gunning did not testify, and there is no written report of this incident in the record.

Zimbric testified that the difficulty and delay in getting the infant's vital signs were associated with finding and adapting the special equipment required to assess oxygen levels and blood pressure for an infant. Zimbric testified that the special equipment to read an infant's oxygen levels and blood pressure could only be connected to a portable machine that records the readings and that the machine in the emergency room was not properly charged. Zimbric obtained an oximeter from the respiratory therapy department that did not need to be connected to the portable machine and recorded the infant's oxygen levels in approximately fifteen minutes. Although the uncharged portable machine could record blood pressure readings if it was plugged in, the machine had the wrong adapter on it to fit the connection from the special infant blood pressure cuff. In order to record the blood pressure readings from the infant cuff, Zimbric had to find another cuff that had the right type of adapter and find a way to attach the adapter to the infant cuff. She obtained the blood pressure readings after approximately thirty minutes. Zimbric also testified that she told Dr. Gunning about the reasons for the delay in getting the patient's vital signs. Zimbric demonstrated professional ability and resourcefulness in finding and adapting the equipment to work as quickly as possible under these circumstances where the hospital and its staff seemingly failed to prepare for infant patients visiting the emergency room.

We find Zimbric's testimony with regard to this patient to be more credible.

Fourteen-year-old patient

The Board alleges and Crist testified that there was a concern with Zimbric's delivery of care to a fourteen year old patient with abdominal pains that resulted in lack of trust from Zimbric's colleagues. Zimbric testified that she did not remember any incident meeting that description. There is no other testimony or specific facts in the complaint or the record with regard to this incident. Although the Board cites this incident in its complaint and includes the allegation in its Proposed Findings of Fact, the Board does not appear to rely on this incident in any of its arguments in support of discipline.

H.M.

The Board alleged that Zimbric did not document that she had applied a "dry dressing" to H.M.'s wound on August 13, 2008 and that she did not record that she had made her "round" with the patient for one hour and seventeen minutes. Crist testified that she verbally counseled Zimbric on August 18, 2008 about documenting all interventions with patients and about expectations that emergency room nurses would make the rounds of their patients every thirty minutes. Crist had no personal knowledge of this incident.

H.M.'s wife filed a complaint about this incident with Barnes and a copy was submitted into evidence. The complaint does not mention Zimbric, but it does mention the doctor on duty by name and is highly critical of the care he provided to H.M. Zimbric testified that she documented the patient's vital signs, the removal of the old dressing and her observations about the condition of the wound. She testified that she did not document that she put a "dry" dressing on H.M.'s wound because it was not an actual dressing. She had to remove H.M.'s bloody dressing in order to assess the condition of H.M.'s wound, and because the wound was not bleeding, she replaced the dressing with only some loose sterile gauze with a little paper tape to keep the wound covered until the doctor saw the patient. Zimbric testified that this was the

appropriate treatment, because she expected the doctor to see the patient within fifteen minutes and the doctor would have to remove any new dressing and adhesive again, further irritating the skin around the wound.

Zimbric testified that she was with H.M. from approximately 5:15 pm until 5:30 pm and that her shift ended at 6 pm., at which time she updated the nurse coming on duty with regard to her patients' status. She also testified that as long as she could remember, the rule in the emergency room was to make the rounds of non-critical patients every hour and that the counseling session with Crist was the first time she was told the rule was every thirty minutes. Crist testified that the rule had always been thirty minutes, but that she did not know where the rule was documented. Zimbric testified that the one hour rule was discussed at monthly nurses meetings and documented in the minutes.

We find Zimbric's testimony with regard to H.M. to be more credible.

Discrepancies in Documentation of Administration of Medications

Crist and Zimbric testified that on August 18, 2008, a routine narcotics inventory revealed a discrepancy of 7.5 milligrams of vicodin. In fact, Zimbric assisted in that inventory. Crist testified that after the inventory, she compared documentation on Zimbric's patients' charts for August 4 and 14, 2008 and a report generated from Pyxis for those days and found the following discrepancies in documentation of Zimbric's administration of medications, including controlled substances:

> The Pyxis report showed that on August 14, 2008, Zimbric withdrew one vicodin for J.L. and two vicodin for S.M, but the patients' charts had no orders for the narcotics;
>
> The Pyxis report showed medications were removed for one patient that did not have an order in their chart and administered to patients with orders in their charts; and
>
> Three other charts had orders for Morphine and/or vicodin.

Crist testified that Zimbric told her that Dr. Landry had given verbal orders for the two vicodin for S.M., and that Dr. Reed told her that Dr. Landry denied giving the order. Neither Dr. Landry nor Dr. Reed testified.

Zimbric denies saying telling Crist that Dr. Landry ordered two vicodin for S.M. Zimbric testified that because S.M. was a drug seeker, such an order would not have been appropriate. She testified that she initially gave S.M. dicyclomine hydrochloride for her upset stomach and later gave her toradol, a non-narcotic pain killer, and that these medications were properly recorded in the Pyxis system and on S.M.'s chart.

Zimbric also testified that a vicodin tablet would not have been appropriate for J.L. because he was scheduled for surgery and was not allowed to have anything orally.

Zimbric described a flaw in the way the Pyxis system dispensed medications that would allow someone to withdraw medication while someone else was logged in. If a user did not log off, the system would keep them logged in for three minutes. During this time someone else could use the system to withdraw medication. This withdrawal would appear on the report under the first user's name and log in code and the name of the patient for whom the first user was withdrawing medications at the time.

Zimbric testified that it was her custom to turn away from the Pyxis machine to prepare medications while waiting for the system to produce a receipt, and that it was common practice for someone else who needed to use the system to log her out (with her permission) and then to log in using their own code before withdrawing medications. Zimbric testified that on both occasions when she withdrew medications for S.M. and J.L., she remembered someone coming up behind her and asking to use the Pyxis system while she was preparing medications and waiting for a receipt. Because of the common practice and because the machine did not produce a sound when someone logged on and off, Zimbric assumed whoever it was behind her had

signed her out before logging in with their own code. The Pyxis report confirms that the vicodin for S.M. was withdrawn right after the dicyclomine hydrochloride.

We find Zimbric's testimony to be credible and the weight given to the Pyxis report to be minimal, as it was admitted subject to objections as to hearsay and foundation.

Subdivision (1): Use or Unlawful Possession of a Controlled Substance

As a nurse, Zimbric may lawfully possess controlled substances while acting in the course of her professional duties.[6] The Board argues that because Zimbric withdrew vicodin and morphine, controlled substances as defined in §195.017, from the Pyxis medication dispensing system without a doctor's orders for the medications, her possession was unlawful. We find that Zimbric's explanation of the discrepancies in the documentation regarding these drugs is credible, and that she did not unlawfully withdraw or possess vicodin and morphine. Accordingly we find Zimbric is not subject to discipline under § 335.066.2(1).

Subdivision (5): Professional Standards

The Board alleges that Zimbric's conduct constitutes incompetency, gross negligence, misconduct and misrepresentation in the performance of her duties as an RN. However, the Board did not present any argument in support of gross negligence and misrepresentation and thus has abandoned these grounds for discipline.

Incompetency is a general lack of professional ability, or a lack of disposition to use an otherwise sufficient professional ability, to perform in an occupation.[7] We follow the analysis of incompetency in a disciplinary case from the Supreme Court, *Albanna v. State Bd. of Reg'n for the Healing Arts*.[8] Incompetency is a "state of being" showing that a professional is unable or

[6] Section 195.180.
[7] *Tendai v. Missouri State Bd. of Reg'n for the Healing Arts*, 161 S.W.3d 358, 369 (Mo. 2005).
[8] *Albanna v. Missouri State Bd. of Reg'n for the Healing Arts,* 293 S.W.3d 423 (Mo. 2009).

unwilling to function properly in the profession.[9] The *Albanna* court held that the evaluation necessitates a broader scale analysis, taking into account the licensee's capacities and successes.[10]

The Board argues that Zimbric's failure to quickly obtain the oxygen saturation levels and blood pressure needed to assess a seven week old patient demonstrates a general lack of professional ability or a lack of disposition to use an otherwise sufficient professional ability. Additionally, the Board argues that Zimbric's failure to document or check on H.M. for an hour and seventeen minutes and her failure to document that she had applied a dry dressing demonstrate a general lack of professional ability or a lack of disposition to use an otherwise sufficient professional ability.

Zimbric used her more than sufficient professional ability and skills to find a solution to the problem with the equipment necessary to assess the vital signs of the infant as quickly as possible under the circumstances. She spent fifteen minutes out of the forty-five remaining on her shift with H.M. and documented everything she did in those fifteen minutes except placing a piece of gauze over the wound that she did not consider to be a dressing that would require documentation. We find that Zimbric's conduct in treating the infant and H.M. did not constitute incompetency.

Misconduct means "the willful doing of an act with a wrongful intention[;] intentional wrongdoing."[11] The Board argues that the "act" in this case was Zimbric's unlawful withdrawal of medication from the Pyxis medication dispensing system. Because we found in II above that Zimbric's explanation of the discrepancies in the documentation regarding these drugs is credible

[9] 293 S.W.3d at 435.
[10] *Id.* at 436.
[11] *Missouri Bd. for Arch'ts, Prof'l Eng'rs & Land Surv'rs v. Duncan*, No. AR-84-0239 (Mo. Admin. Hearing Comm'n Nov. 15, 1985) at 125, *aff'd*, 744 S.W.2d 524 (Mo. App., E.D. 1988).

and that she did not unlawfully withdraw the vicodin and morphine, we find here that Zimbric's acts did not constitute misconduct.

Accordingly we find Zimbric is not subject to discipline under § 335.066.2(5).

Subdivision (6)

The Board alleges there is cause to discipline Zimbric's license under § 335.066.2(6), but its complaint contains no statute or regulation under Chapter 335 that she allegedly violated. We cannot find cause to discipline for uncharged conduct.[12] Zimbric is not subject to discipline under § 335.066.2(6).

Subdivision (12): Professional Trust

The Board alleges that Zimbric violated a professional trust or confidence. Professional trust is reliance on the special knowledge and skills that professional licensure evidences.[13] It may exist not only between the professional and his clients, but also between the professional and his employer and colleagues.[14]

The Board argues that Zimbric's failure to properly test and monitor her patients and to document patient interventions violated the professional trust placed in her by her patients, her co-workers and the doctors. This is the same conduct on which the Board based it's allegation of incompetency. The Board argues further that Zimbric's failure to properly document and administer medications violated the professional trust placed in her by her patients, her co-workers and the doctors. These are the same acts on which the Board based it's allegation of unlawful possession of a controlled substance.

We previously found that Zimbric did not improperly withdraw or dispense medications. We also found that Zimbric did not fail to properly test and monitor her patients and document

[12] *Dental Board v. Cohen*, 867 S.W.2d 295, 297 (Mo.App. W.D. 1993).
[13] *Trieseler v. Helmbacher*, 168 S.W.2d 1030, 1036 (Mo. 1943).
[14] *Cooper v. Missouri Bd. of Pharmacy*, 774 S.W.2d 501, 504 (Mo. App. E.D. 1989).

patient interventions. Therefore, we find here that she did not violate any professional trust or confidence to her patients, her employer, or her colleagues.

Accordingly, Zimbric is not subject to discipline under § 335.066.2(12).

Subdivision (14) Violation of State Drug Laws

The Board alleges that Zimbric violated §195.202.1: "[e]xcept as authorized by sections 195.005 to 195.425, it is unlawful for any person to possess or have under his control a controlled substance." Because we found that Zimbric did not unlawfully possess a controlled substance, we find here that she did not violate § 195.202.1. Accordingly, Zimbric is not subject to discipline under § 335.066.2(14).

Timeliness of Payne's Complaint to the Board

Zimbric asks us to find that Payne's complaint to the Board was not timely filed, and therefore, the Board's complaint to this Commission should be dismissed.

Zimbric argues that 20 CSR 2200-4.040(2),[15] the mandatory reporting rule, required Payne's complaint to the Board to be "submitted within fifteen (15) days of the final disciplinary action." The rule defines "final disciplinary action" as "any final action taken by the board of trustees or similarly empowered officials of a hospital … to reprimand, discipline, or restrict the practice of a health care professional." Zimbric was suspended on August 19, 2008 and resigned on August 22, 2008. Even if Zimbric's coerced resignation is considered a disciplinary action, the deadline for filing the complaint would have been September 8, 2008 (the fifteenth day, September 6, was a Saturday). Payne's complaint to the Board is dated September 9, 2008 and was not received by the Board until September 12, 2008.

[15] Zimbric actually cites 22 CSR §2200-4.040(2), but there is no such rule. This rule also requires mandatory reporting for voluntary resignations under certain circumstances, but it is not clear if the fifteen day requirement applies to those complaints. All references to "CSR" are to the Missouri Code of State Regulations, as current with amendments included in the Missouri Register through the most recent update.

We find that 20 CSR 2200-4.040 is not a bar to this action. The regulation is not a statute of limitations. The regulation does not bar the Board from acting if a hospital does not notify the Board. Rather, the regulation requires hospitals to notify the Board of discipline against nurses so that the Board can investigate the nurses and take appropriate and timely action against the nurses' licenses. Reading the regulation as a statute of limitations would make hospitals—not the Board—the arbiters of professional discipline. It also would potentially impede the Board from seeking discipline based solely on a hospital's paperwork errors and lack of reporting. The primary purpose of professional licensing is to protect the public.[16] Zimbric's position would not help the Board protect the public. To the contrary, Zimbric's position would weaken the Board's ability to seek professional discipline against nurses. We therefore find that 20 CSR 2200-4.040 does not bar this action.

Summary

We find no cause exists to discipline Denise Zimbric's registered nurse license.

SO ORDERED on July 2, 2013.

\s\ Nimrod T. Chapel, Jr.
NIMROD T. CHAPEL, JR.
Commissioner

[16] *Lane v. State Comm. of Psychologists*, 954 S.W.2d 23, 25 (Mo. App. E.D. 1997)